LOS ANGELES COUNTY COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

June 19, 2014

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF/ CONSULTANTS
Grissel Granados, MSW, *Co-Chair*	Mitchell Kushner, MD, MPH	Marc Davis, DDS	Jane Nachazel
Fariba Younai, DDS, *Co-Chair*	Carlos Vega-Matos, MPA	Michael Pitkin	Craig Vincent-Jones, MHA
Raquel Cataldo		Jason Wise	
Kevin Donnelly			
Dahlia Ferlito, MPH (pending)	**MEMBERS ABSENT**		**DHSP STAFF**
Suzette Flynn	Terry Goddard, MA		None
David Giugni	Patsy Lawson/Miguel Palacios		
Kimler Gutierrez (pending)	Angèlica Palmeros, MSW		

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Standards and Best Practices (SBP) Committee Agenda, *6/19/2014*
2) **PowerPoint**: LA County Eligible Metropolitan Area for Ryan White Patients Receiving Oral Health Services, *6/19/2014*
3) **PowerPoint**: LA County's Ryan White-funded Oral Health Care Services: Navigating Denti-Cal Restoration and Defining RW "Wrap-Around" Support, *6/19/2014*
4) **Table**: Denti-Cal Schedule of Maximum Allowances, *6/19/2014*
5) **Table**: CDT Code RW Justifications, *6/19/2014*
6) **Article**: "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7," *2011*

1. **CALL TO ORDER:** Ms. Granados called the meeting to order at 9:20 am.

2. **APPROVAL OF AGENDA:**
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES:**
   MOTION #2: Approve the Standards and Best Practices (SBP) Committee meeting minutes, as presented **(*Postponed)***.

4. **PUBLIC COMMENT, *(Non-Agendized or Follow-Up)*:** There were no comments.

5. **COMMITTEE COMMENT, *(Non-Agendized or Follow-Up)*:** There were no comments.

6. **CO-CHAIRS' REPORT:**
   - Additional SBP meetings were scheduled for 9:00 am to 12:00 noon on: 6/26/2014, work plan and list of service definitions; and 7/3/2014, continuum of social determinants. The regular 7/17/2014 meeting will address the housing continuum.

7. **ORAL HEALTH SERVICES:**
   A. **Technical Assistance (TA) Report on Ryan White-funded Oral Health Capacity**:
      - Mr. Vega-Matos reported DHSP and the Commission worked jointly for years to expand oral health services. Most adult Denti-Cal services were cut in 2009, but Ryan White capacity tripled and procedures expanded in the last three years. In particular, DHSP wanted to preserve and restore teeth rather than extract them as safety net programs generally do.

- A secret shopper program was part of expansion analysis. Some clinics that were part of a medical home only saw that medical home's clients. Other clinics did not know where to access oral health services or paperwork was excessive.
- DHSP met with providers to address issues including customer service. The standard of care requires an annual oral health exam so, with a system capacity of 3,000 people, clinics cannot restrict services to its clients. Medical providers should ensure referral and oral health providers should see visits as openings to return out-of-care clients to care.
- Timothy Martinez, DMD, (HRSA TA) was engaged for an outside perspective. DHSP has approximately $7.5 million in currently allocated resources following the three year oral health expansion – the third largest category after Ambulatory Outpatient Medical and Medical Care Coordination. Providers have risen from four to twelve or thirteen.
- DHSP also established the Oral Health Advisory Committee (OHAC) comprised of program dental directors and the Department of Public Health (DPH) dental expert who also consults for the Department of Health Services' network.
- TA is two-pronged. One focus assesses Ryan White capacity including appropriate dentist-hygienist ratio, number of patients per chair, appropriate staffing per chair, dental and endodontic service need, and additional needed services.
- Because Ryan White is a payer of last resort, the second prong assesses other oral health resources.
- The evaluation methodology used Phase 1 treatment data, 3/2012-2/2013, and Case Watch data, 1/2012-12/2012.
- The four treatment levels are: 1. emergency; 2. primary (prevention); 3. secondary (restorative); 4. limited rehabilitation, e.g., crowns and dentures. Dr. Davis felt Level 4 services address infection so would be better classified with Level 1. Mr. Vega-Matos has found various views regarding levels in standards and among providers. Dr. Younai felt it would be valuable to review the original level definitions and how levels were developed.
- High percentages of patients for all of the clinics, 79% up to 98%, received CDT Code procedures during the year. Not all of the procedures were necessarily completed during the year, but the CDT Codes were used.
- This is a first look at data since not all current providers had fully ramped up Phase 1 services during the study period.
- There are few oral health benchmarks. Most that have been established are for Federally Qualified Health Centers (FQHCs). Half of DHSP clinics are FQHCs so DHSP is using their benchmarks initially. DHSP is also talking with HRSA about benchmarks used by other Eligible Metropolitan Areas (EMAs). Dr. Davis preferred averaging DHSP clinic data to establish benchmarks, but Mr. Vega-Matos said DHSP is seeking outside measures to compare with historical data.
- HRSA minimum expectations are: 2,500 visits per year, 13.7 visits per 8 hour day and 1.7 visits per hour per FTE dentist; and 3 procedures per visit. DHSP provider averages are: 1,301 visits per year, 6.15 visits per 8 hour day and 0.8 visits per hour per FTE dentist; and 2.2 procedures per visit. DHSP is talking with private dentists and the HRSA TA and DPH consultants to evaluate data, e.g., is data missing from the system or would chart review reveal pertinent information.
- For example, what reasons underlay the gap of 1,199 visits per year per FTE dentist between the benchmark of 2,500 and the provider average of 1,301. Data may be missing. Efficiencies might also foster improved data, e.g., some providers had very high rates of no shows or cancellations at baseline. Chart review showed many patients could not be seen because they arrived late or on the wrong day. Appointment reminders could help reduce those issues.
- Dr. Davis estimated 20% of his oral health patients at APLA do not attend their appointments on any given day despite a prior day phone confirmation. Mr. Vega-Matos agreed it is a major issue that needs to be examined and addressed.
- A prior shortage of hygienists and dental assistants may also remain an issue affecting productivity.
- Data from the two dental schools needs to be reviewed in light of their service to a somewhat different population and access to independent resource streams which differ from community clinic populations and resources.
- DHSP plans to identify benchmarks by the end of 2014 for incorporation into contracts. Providers will also be expected to develop an emergency management policy and a methodology to track completion of Phase 1 treatment plans.
- Mr. Vega-Matos noted not all providers offer all treatment levels. In 2008 or 2009, providers expressed concern that their set-ups were not designed for Level 4 services. USC was contracted to provide endodontic services and UCLA has since been added. Dr. Davis felt all providers should be able to provide lower acuity Level 4 services such as crowns and bridges. Mr. Vega-Matos replied some smaller providers feel they cannot do so, but that will be part of assessment.
- Acuity levels are part of the system for other programs, but will take significant time to develop for oral health.
- Ms. Flynn felt benchmarks for the number of visits per FTE dentist were too high. Ms. Cataldo added treatment plans at her clinic were so extensive and complicated that she was grateful if dentists could see 10 patients a day.
- Dr. Younai stressed the importance of data reflecting matched populations. FQHCs serve large numbers of patients who are not PLWH so using their benchmarks is inappropriate. Historical data or data from other jurisdictions would have greater validity. Mr. Vincent-Jones added FQHC undocumented patients have lower acuity levels than Ryan White patients, do not need to visit as frequently and fewer are new to care.

- Dr. Younai added three procedure codes per visit can be irrelevant to meaningful treatment plan outcomes. "Assessment" can be equivalent to, "Hello." "Prevention" can be equivalent to, "Did you brush your teeth?"
- She was concerned DHSP did not first request SBP input in developing its analysis. Mr. Vincent-Jones added using another system's standard of care rather than adhering to our own is a fundamental flaw in the study. The Commission developed standards of care for all services. That is a special challenge when providers have already offered the service for years as was the case with oral health so the Commission chose to use then current contracts for much of the work.
- The Commission made a conscious choice not to detail the number of patients per day or procedures per patient. Those choices were made both because it is difficult to access such information under the cost reimbursement system and because the Commission wanted providers to have time to assimilate the standards before setting case loads.
- The Commission is now taking an active role in reconciling Ryan White and Denti-Cal coverage prompted by Mario Pérez's Commission meeting comment about a standards issue. The Commission responded that it should address any standards issue, ambiguity, information gap or problem for the grantee as part of its responsibility.
- Mr. Vega-Matos emphasized DHSP was not equating the study with the standard, but just acquiring a fresh view. Dr. Davis said many at the OHAC meeting perceived the study as assessing the system rather than one aspect of review. Mr. Vincent-Jones added he had heard DHSP was moving to the FQHC standard rather than only using its metrics. Communication should be clarified, but he also felt the Commission should have been consulted regarding metric use.
- Mr. Vega-Matos noted Dr. Martinez presented by phone so perhaps some clarity was lost. He did say research was continuing, but he wanted a comparison population. FQHC data was chosen since FQHC populations include PLWH and those with applicable social determinants, e.g., the homeless. Half of DHSP providers are also FQHCs.
- Mr. Vincent-Jones previously worked at an FQHC and reported standards are much lower than the Commission's just as Medi-Cal standards are lower. The Ryan White Program envisions and funds higher expectations. FQHCs do have metrics available, but that only highlights the Commission's charge to develop appropriate metrics in a timely manner. Dr. Martinez, as an HRSA TA, should know to consult with the local planning council. Mr. Vega-Matos said DHSP attempted unsuccessfully to schedule an OHAC meeting, but Mr. Vincent-Jones noted OHAC is not the planning council.
- He continued Fee-For-Service (FFS) is a procurement process so HRSA and DHSP resisted when the Commission first raised the subject, but there is room to discuss providing appropriate data since data impacts standards. Mr. Vega-Matos noted five service categories now use FFS. Methodology was developed with community input.
- He added several EMAs, including some nearby, use FQHCs for all oral health care. He planned to visit. Dr. Younai felt this EMA is setting the national standard so other EMA practices are irrelevant, but Mr. Vega-Matos responded there is always something to learn, e.g., to improve program administration or monitoring.
- Dr. Younai noted oral health is the subject for the first Evaluation of Service Effectiveness (ESE). The ESE could offer data for analysis. She and Dr. Davis also had heard an initial presentation by Dr. Martinez on his SPNS study. The data presented at the time was limited, but other data should be available from the study.
- Mr. Vega-Matos emphasized that the landscape is changing. DHSP is making decisions about who is eligible for restored Denti-Cal, but the state made changes as late as 5/4/2014 and rules for the half of providers that are FQHCs differ from those for other providers. Mr. Vincent-Jones stressed all providers must meet minimum standard expectations for their contracted services such as for Level 3 including appropriate staffing for dentists, hygienists and dental assistants.

➲ Mr. Vega-Matos will refer discussion of the origins of current treatment levels to the next OHAC meeting.

➲ DHSP will clarify language to ensure FQHC data is not perceived as the "standard."

B. Reconciliation of Denti-Cal Restoration with Local Ryan White Coverage:

- Mr. Vincent-Jones re-iterated that Mr. Pérez commented at a Commission meeting that there were definitional issues between the Commission's and Medi-Cal's standards. It is the Commission's responsibility to address those issues.
- The Commission expected the need to address ACA wrap-around issues. Denti-Cal is a state program, but issues are the same. HRSA usually allows a year to identify wrap-around services, but wants an immediate response on what wrap-around services are needed to maintain the Commission's standard of care for Denti-Cal patients.
- All providers use the same American Dental Association procedure codes, but the definition of a procedure can be an issue. Medicare and Medicaid (Medi-Cal and Denti-Cal) law requires providers of funded services to accept that payment in full for a procedure, i.e., another federal funder cannot supplement payment for a procedure.
- Federal procedure definitions may not distinguish quality, e.g., Denti-Cal applies "crown replacement" to all crowns. Steel crowns, however, are designed for short-term needs such as pediatric applications while porcelain crowns last

much longer and are the Commission's standard expectation. On the other hand, ADA codes describe eight ways of doing crowns so it can be argued that Denti-Cal is arbitrarily merging codes on the ADA list it purports to use.

- Mr. Vega-Matos reported, per HRSA conversations to date, that Ryan White cannot wrap-around capitated Medi-Cal Expansion (HMO). A few patients remain on original Medi-Cal FFS. Ryan White can fund wrap-around services for them.
- DHSP is evaluating the state's April 2014 guidance that lists services Ryan White Part B cannot wrap-around when provided through ACA coverage. Services listed are: ambulatory outpatient medical, home health, substance abuse, mental health and one other (not oral health). Mr. Vincent-Jones said that would contradict previous information that Ryan White can cover, e.g., needed mental health visits that exceed the cap. The guidelines may have errors.
- Mr. Vincent-Jones stressed that exemplifies the importance of definitions. They determine what can be covered.
- The first spreadsheet lists all ADA codes for procedures Denti-Cal classifies as allowable. Denti-Cal chooses what to actually allow from the list. The fourth column reflects a "Yes" if the procedure is covered under the new 2014 Denti-Cal. Ryan White cannot cover those. The prior iteration of Denti-Cal covered more procedures per the fifth column. FQHCs sued to retain coverage for those procedures and won on grounds that the state cannot limit federal coverage.
- The FQHC justification for those procedures should apply to Ryan White so no separate justification for HRSA was planned. Mr. Vega-Matos said HRSA, not the state, prohibits Ryan White from covering a service covered by another payer, but Mr. Vincent-Jones felt County Counsel could explore the inequity in broader coverage for FQHCs than for Ryan White providers. Dr. Davis added a patient leaving an FQHC for another provider would otherwise lose coverage.
- The sixth column reflects procedures not covered by either Denti-Cal or expanded FQHC coverage, but necessary to meet the Commission's standard of care. These need to be justified individually to HRSA, i.e., the need, why they are HIV-related and need by EMA clients. Dr. Davis noted the third column reflects allowances. Denti-Cal labels some "global" and assumes they should be done, but does not cover them separately. Justifications were done for those and some benefits Denti-Cal does not allow because it was agreed they should be addressed on their own merits.
- Dr. Younai sought unbiased justifications so enlisted the Oral Health Advisory Group for the Pacific AIDS Education Treatment Centers. Members divided up codes and wrote justifications for why any client would need the procedures. Literature was not included for space reasons, but is available. Mr. Vincent-Jones said the ultimate goal is to make the justification document available publicly so a common language iteration will be needed as well.
- He continued several other steps are needed to ensure no procedures necessary for clients consistent with the standard of care are missed. The current list needs to be compared against the original ADA code list to ensure no codes are missing from the allowable list. Current practitioners and Case Watch will be reviewed to identify procedures commonly covered, being done or paid for in current practice that are not represented on the list or any such procedures that lack codes. The finalized list will be presented to the Commission and discussed with DHSP.
- The Commission can then advocate support for these procedures with HRSA. Procedure rates are a grantee responsibility and DHSP has worked on them, but the Commission can review rate ranges for informational purposes.
- When procedure work is done, the Commission will need to revise the Oral Health Standard of Care for greater precision especially regarding minimum expectations. OHAC is being scheduled as the Expert Review Panel and will have the updated OHAG guidelines available for review.
- Finally, this situation highlights the issue of FFS versus cost reimbursement since the latter now requires oral health providers to translate their expenses into the cost of various procedures rather than the grantee identifying such costs.
- Mr. Vega-Matos reported conversations continue with HRSA to clarify what Ryan White can cover. As he understands their view, the FFS environment still in effect for the few remaining patients in original Medi-Cal does not cover some services considered part of the standard of care in its broader sense. Consequently, Ryan White can cover certain of those services depending on how they are impacted by the initiation of ACA.
- Ryan White cannot supplement services covered under a capitated plan such as Medi-Cal Expansion. Questions remain about Ryan White coverage if, e.g., Denti-Cal covers a procedure such as a crown but does not distinguish steel from porcelain. Ryan White is a payer of last resort so DHSP must verify: income, residency, HIV status and other insurance.
- Mr. Vincent-Jones stressed the Commission's standard of care reflects minimum expectations. Negotiations with HRSA can highlight the error in conflating procedures that should be evaluated separately and pertain to the continuity of care. Net County Cost can be used to pay for such services while negotiations are ongoing.
- Mr. Vega-Matos preferred not releasing the list until DHSP can work with providers to identify what procedures should be billed to what funding source. DHSP is working on that aspect of procedure evaluation which is needed for tracking and provider audit purposes. Dr. Younai noted justifications are highly technical so felt experts should be involved.

- Mr. Vincent-Jones felt the issue again was an impetus for s shift to FFS, but Mr. Vega-Matos replied FFS rates are for visits rather than procedures. Multiple codes may be addressed in any one visit.
- Dr. Davis urged ensuring all oral health providers can provide the same services that FQHC providers offer as a first step. Mr. Vega-Matos reported DHSP is supporting non-Denti-Cal providers in becoming Denti-Cal and billing for Denti-Cal covered codes. DHSP believes the gap between Denti-Cal and FQHC codes could be billed to Ryan White.
- Mr. Vega-Matos stressed DHSP has emphasized providers should not turn patients away. Mr. Vincent-Jones replied providers felt DHSP communication was confusing and were concerned about reimbursement for their services.
- Mr. Vega-Matos pointed out DHSP had nearly two years to prepare for the ambulatory outpatient medical transition. Denti-Cal, however, has been re-initiated with little notice and few resources to prepare providers and the system. DHSP is working as quickly as possible. Mr. Vincent-Jones said, while the Commission supported as expeditious a process as possible, it would likely take at least six months to effectively prepare materials to negotiate with HRSA.
- Providers cannot, however, go six months without assurance of reimbursement. He urged DHSP to develop an interim plan so providers can manage their finances. Dr. Younai added laboratory costs should be included as well.
- Mr. Vincent-Jones stated the Commission's role is to define and interpret the Oral Health Standard of Care. It also has a role in speaking with HRSA to underline its legislative role in developing standards and to support its partner, DHSP. The reimbursement system is DHSP's role though the Commission may offer its input.

➲ Mr. Vega-Matos will obtain for distribution the state's April 2014 guidance on acceptable Ryan White wrap-arounds.
➲ Mr. Vincent-Jones will research whether Covered California and/or Medi-Cal lists oral health as an essential benefit.
➲ Mr. Vincent-Jones will develop a common language iteration of the codes justification document.
➲ DHSP will add clarifying language to its memorandum regarding support to its providers.
➲ The code lists are not public documents at this time.
➲ Mr. Vega-Matos will attend the next OHAG meeting to discuss Ryan White funding rules and regulations.
➲ This process will be presented at the 7/10/2014 Commission meeting. Lists should be ready by the 7/24/2014 meeting.

MOTION #3: Approve the proposed LA County Ryan White Part A-funded oral health care coverage as reconciled against Denti-Cal coverage provided by Medi-Cal in the State of California, as presented **(*Postponed)***.

8. DETERMINANTS FRAMEWORK:

A. "Behavioral Model of HIV Services": There was no discussion.
MOTION #4: Adopt the "Behavioral Model of HIV Services," an adaptation of the "Behavioral Model of Health Services" (R. Andersen, author) as the Determinants Framework in the HIV Services Continuum, as presented **(*Postponed)***.

9. CONTINUUM OF HIV SERVICES:

A. Incorporating the Determinants Framework into the HIV Continuum: There was no discussion.
MOTION #5: Approve the conceptual framework and Continuum-based format for identifying service categories/services/interventions and their subsequent definitions, to be completed at a later date, as presented and discussed **(*Postponed)***.

B. List of Service Definitions: There was no discussion.

10. POPULATION-SPECIFIC GUIDELINES:

A. Guidelines Format/Structure/Instruction: There was no discussion.
MOTION #6: Approve the format and instructions for the Population-Specific Guidelines, as presented, revised and discussed **(*Postponed)***.

B. SOC for the Health of Transsexual, Transgender, Gender Nonconforming People, #7: There was no discussion.

11. NEXT STEPS: There was no discussion.

12. ANNOUNCEMENTS: There were no announcements.

13. ADJOURNMENT: The meeting adjourned at 12:30 pm.